South Carolina Ryan White Part B
Case Management Standards

Case Management Guidance 1.0: Intake and Assessment

CM 1.1 Initial Contact and Registration

The time from the first call by referring agency or by the client to the time a case manager contacts the client should be two (2) working days. Registration can be done by a registration person or the case manager. Each agency will establish written guidelines for respective Registration procedures.

CM 1.2 Intake

The time from the case manager's initial contact call to the face to face Intake shall not exceed five (5) working days. The Intake will consist of signed releases of information, consents for services, and client rights and responsibilities, as well as the collection of basic demographics.

CM 1.3 Assessment

The assessment can be completed at the time of intake, but must be completed no later than thirty (30) working days from the date of intake, and should be signed by the client and the case manager. The assessment shall include information on housing and household members, risk reduction, dental, legal, education, employment, insurance, financial, medical (including a screening of the client's HIV knowledge), mental health, substance use/abuse, domestic violence, cultural beliefs and practices, and help required. In addition to the assessment form, the benefit assessment tool must be completed on each client. A service plan must also be completed at the time of assessment, based on identified needs, and should be signed by the client and case manager.

A sample Intake/Assessment is available from S.C. D.H.E.C. for interested service providers. This sample provides an example of the minimum requirements. Agencies may add additional information to better fit their needs, however, since these are minimum requirements, information should not be DELETED. Each agency will establish written guidelines for respective assessment procedures.

CM 1.4 Reassessment

The reassessment should be done in person, annually, with the client, and should be signed by the client and the case manager. The reassessment should include updated releases, consents, and client rights and responsibilities as well as information on housing and household members, risk reduction, dental, legal, education, employment, insurance, financial, medical (including a screening of the client's HIV knowledge), mental health, substance use/abuse, domestic violence, cultural beliefs and practices, and help required.

A new benefit assessment tool must also be completed with the client. A service plan must also be completed or updated at the time of Assessment, based on identified needs, and should be signed by the client and case manager.

A sample reassessment is available from S.C. D.H.E.C. for interested service providers. This sample provides an example of the minimum requirements. Agencies may add additional information to better fit their needs, however, since these are minimum requirements, information should not be DELETED.

Case Management Guidance 2.0: Tracking

CM 2.1 Mid-Year Review

A mid-year review must be completed on all active clients receiving case management services. This review is to be completed six months after the client's intake/assessment or annual reassessment date. This review shall include HIV knowledge screening and a service plan review. HIV knowledge screening must address the following topics: 1) Importance of CD4 count/viral load monitoring; 2) HIV transmission risk/factors; 3) Importance of regular medical care; and 4) Assessment of the client's understanding of HIV information.

CM 2.2 Service Plan

The service plan is a shared-responsibility contract. It is required that a service plan be completed at intake/assessment with all clients and serve as the guide for services provided. The service plan includes what is to be done by the case manager, what is needed from the client, and a time frame for completion. The service plan should be signed by the client and the case manager and be reflective of identified client needs and services being provided. The service plan will change and be updated as needed; however, the service plan must be reviewed with the client at the client's mid-year review and annual reassessment.

CM 2.3 Referral Tracking

Referral tracking should be done for all Ryan White core services, including substance abuse, mental health, medical and dental referrals. Referrals to other agencies can also be tracked as program capacity allows. All required referrals should be followed up within thirty (30) days. Factors impacting the required time to follow-up include the urgency of the needed service, referral agencies' procedures, etc.

CM 2.4 Face to Face Contact

First contact must be an Intake/Assessment. Subsequent contacts, depending on the needs of the client, are to be scheduled as deemed appropriate between the case manager and the client. In addition, the annual reassessment must be a face to face contact.

CM 2.5 Home Visits

Home Visits are one of the best ways to know how a client lives and to determine what services are needed. A home visit should be made at least once in the first year of service (new clients). Home visits, however, depend on the level of comfort expressed by the client with the case manager entering their home, residence status (e.g. homeless), client trust, confidentiality, safety of the case manager, etc. Subsequent visits, depending on the needs of the client may be scheduled as deemed appropriate between the case manager and the client.

Case Management Guidance 3.0: Discharge

CM 3.1 Case Discharge Summary

A client's case is to be closed when he/she requests discharge or when he/she is deemed inactive, deceased, or discharged in accordance with each agency's guidelines. Client discharges should be signed by the case manager and case management supervisor.

Case Management Guidance 4.0: Documentation

CM 4.1 Progress Logs/Notes

Case Managers (CM) will complete a minimum of one progress log per day for each client served. This allows a case manager to complete one progress log that explains all activity and services provided to a client (CL) during the course of a day. Multiple services can be linked to the progress log to account for the different services that may be provided to a client throughout the day. Each agency will establish written guidelines for respective documentation.

All progress logs must contain the following information:

Activity Date: The date that the contact was made with the client and services were provided.

Length: The total time of the activity/activities with a client or on the client's behalf, including documentation time. It is recommended that time be tracked in 15 minute increments.

Contact Flag: This notes whether the contact type was **made, attempted,** or **none.**

- **Made** contact is when the CM actually speaks with or meets with the CL, CL's family, other service providers/agencies about the CL's care. **Made** contact also includes any contact from the CL, collateral contacts (e.g. CL's family), or service providers to the CM. Examples include voice mails left for the CM by the CL; letters to the CM from the CL; emails from the CL to the CM.

- **Attempted** contact is any attempt from the CM to contact the CL, collateral contacts, or other service providers about the CL's care. **Attempted** contact includes letters to the CL from the CM; messages left for clients or their collateral contacts by the CM.
- **None** should be used when the CM has no direct involvement with a CL or CL's collateral contacts and no service is being delivered. Examples may include a CM documenting that a CL was a "no show" for an appointment or when a CM is working on a client's file or service plan for the purpose of organizing or filing.

Contact Type: Provides information on how the CM provided services to a client. With documenting all activity with or on behalf of a client, CM will need to prioritize their contacts in the following order when multiple contacts are being documented in one progress log:

1. Made: Face to Face with CL
2. Made: Not Face to Face with CL
3. Made: Face to Face Collateral
4. Made: Not Face to face Collateral
5. Attempted: CL Contact
6. Attempted: Collateral Contact
7. None: CM Documentation

*Collateral contact is any contact not made directly with the client despite the client's age, mental capacity, etc.

Brief Description: A 2-3 word description of the activity with the CL/services provided.

Full Description: Detailed professional/legal documentation of activities and services delivered by the CM. The progress log should be free of slang and professional opinions, and use minimal abbreviations.